# Regionalization Workgroup

**Discussion Paper - Meeting # 5**

Prepared by Technical Assistance Collaborative, Inc.

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The topics of this Discussion Paper include:

1. Present additional possible functions of regions for consideration by the Workgroup;
2. Discuss the issue of "residency" as it applies to regions;
3. Discuss the criteria for regional "formation" and "readiness to proceed";
4. Re-consider the timeline for regional formation and operations; and
5. Discussion of the potential interface between regions and Medicaid, particularly with regard to the home and community based waiver(s).

## *A. Additional possible functions of regions*

At the last meeting Bob Lincoln presented a list of possible additional functions of regions. These include (the items listed below are taken from Bob Lincoln's written submission):

1. Allow Regions to contract with DHS to provide Interim Assistance Reimbursement for individuals with pending applications for disability under Social Security.

2. Give Regions authority to hire Mental Health Advocates as currently allowed for counties with populations over 300,000. Ultimately, it would be a dramatic improvement and cost savings to the Mental Health & Disability system to change Advocates to Case Managers. In the beginning, Advocates helped get individuals out of state institutions now they work to get individuals to their outpatient appointments and stay connected with their providers. The case management role more accurately meets the need of individuals under a mental health commitment.

3. Make the Regional Designated Case Management Agencies the Access Points to apply for the Waiver programs. The Case Management Agencies then forward the request onto DHS workers

and into ISIS (state database) while helping applicants access the best Waiver. Case Management can help with interim services while individuals are waiting for a slot. Under the current structure, individuals apply for several waivers and do not find out if they qualify until after waiting several months.

4. Give Regions the ability to contract with the state Mental Health Institutes and Resource Centers for beds. Communities cannot provide adequate crisis stabilization without an institutional option for individuals deemed to be too unsafe to serve in the community.

5. Give the Regions the ability to include Substance Abuse Detox charges; charges for children admitted to Toledo and non-state cost of shelter care within their budget to better integrate services for individuals.

6. Assign Money Follows the Person (MFP) Case Managers to each Region. This would improve coordination efforts to reduce Iowa's dependence on institutional care.

TAC believes that all of these functions could be legitimate for regions. In fact, to some degree these functions replicate activities or responsibilities already carried out by counties under their management plans. After discussion n with the Workgroup, and based on the degree of consensus reached, TAC will amend the list of regional functions as discussed on the conference call on October 19th.

***B. Residency***

The definition of residency used by the counties is as follows:

*"County of residence" means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good-faith intention of living permanently or for an indefinite period.* ***The "county where a person is living" does not mean the county where a person is present for the purposes of receiving services in a hospital, correctional facility, nursing facility, or residential care facility, nor for the purpose of attending a college or university.*** *The county of residence of an*

*adult who is a homeless person is the county where the adult usually sleeps.* ***The "County of Residence" may be transferred using procedures in Section 153.53(1)a. of these rules."***

The new definition of residency as approved by the MHDD Commission is quoted below:

"*County of residence" means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good faith intention of living permanently or for an indefinite period. The "county where a person is living" does not mean the county where a person is present for the purpose of receiving services in a hospital, a correctional facility, a halfway house for community corrections or substance abuse treatment, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility, nor for the purpose of attending a college or university. For an adult who is an Iowa resident but falls within the exclusion for "county where a person is living" as described in this rule, the county where the adult is physically present and receiving services shall be the county of residence. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps.*

The key issue for discussion by the Workgroup is: How to prevent the concept of residency from becoming another form of "legal settlement" while at the same time assuring the integrity of local levy funds managed by the regions?

TAC and our affiliates have conducted studies of this issue in several states that use regional allocations, in some cases supported/enhanced by local levy funds. We have found that in fact the issues between regions about residency and costs occur much less frequently and with much less financial impact than originally anticipated. Several states have adopted methods for cross-regional funds re-allocation and reconciliation, and to our knowledge they have rarely or never been implemented. One reason for this is that cross-regional migration is much less frequent than anticipated. Another reason is that cross regional migration seems to even itself over time.

By converting from 99 county boundaries to 5 – 15 regional boundaries, many of the cross boundary issues will be mitigated. This will particularly be true if regions are carefully formed to reflect natural affiliations and patterns of service access and utilization. In addition, assuming that the regions receive state appropriated funds as well as local levy funds, these state funds can be used to serve people who do not have historical residency within the boundaries of the region. Finally, after 2014 many if not most individuals will be eligible for Medicaid. With a few exceptions (e.g., ICFs/MR; PMICs) Medicaid is a person based rather than place based reimbursement system. Both slot allocations and waiting lists for the HCBS waivers are already managed at the state level. State funds can also be considered to be person based rather than place based.

For all the above reasons, TAC believes that residency should never be used as a basis to deny service access or to try to claim that another region has fiscal responsibility for a person. The MHDD system should be treated as a state-wide program managed regionally. Data related to cross-regional migration and costs can be analyzed at the state level. If service access disparities can be documented to arise from excessive cross-regional migration, then DHS can re-allocate state resources to correct the imbalance.

### *C. Criteria for regional formation and readiness to proceed*

As noted in the Regional Workgroup draft recommendations reviewed by conference call on October 19th, there was no clear consensus on the criteria for "when a region is ready to start". Criteria discussed during the last meeting included:

- Identification of the member counties.
- Meeting all regionalization criteria to be included in the statute.
- Approval by County boards of commissioners of "letters of intent" to form a region.
- Approval of a 28E agreement by each of the participating counties (boards of Supervisors, it is assumed).
- Draft of the first regional management and strategic plan (it was noted that this would be a "transition plan," not a complete management and strategic plan).

TAC recommends a two phase approach to the **formation** and **implementation** of regions.

For the "formation" phase, TAC recommends that the criteria include:

- The counties to comprise a region have been identified.
- The County Supervisors have signified their intent to join a certain region through a written letter of intent.

- The regional formation proposed by the participating counties meets all the statutory criteria included in the enabling statute enacted (hopefully) by next spring.
- DHS agrees in writing to the participating County Boards of Supervisors that the counties forming the region are in compliance with statutory requirements.

Once the following criteria have been met, a regional group can begin receiving technical assistance and support from DHS. There is no necessity for regions to wait until the end of the process to indicate their intent to form a region and to receive DHS approval.

For the "implementation" phase, TAC recommends that the following criteria constitute a "readiness review" for a region to receive a full-fledged performance contract and to begin full operations:

- A 28E agreement has been signed by the parties.
- The County Supervisors in each participating county have voted to approve the 28E agreement.
- The County Supervisors of designees to constitute the governing board have been appointed/identified.
- An executive has been identified/engaged for the regional group.
- A "transition" regional management/strategic plan has been drafted which identifies the steps to be taken to (a) designate access points; (b) designate TCM; (c) identify the provider network; (d) define the service access/service authorization process; (d) identify the IT/data management capacity to be employed to support regional functions; and (e) establish business functions, funds accounting, etc.
- DHS has approved the 28ER agreement and the "transition" plan.

### *D. Timeline for regional formation and implementation*

As noted in earlier discussions, SF 525 specifies an implementation date of July 1, 2013.

TAC recommends the following time line based on the criteria listed above:

| Date | Activity | Comments |
|---|---|---|
| April 2012 or thereabouts | Enactment of the enabling statute for the MHDD system redesign. | Criteria for regions, requirements for 28E agreements, etc. are expected to be included in this statute. |
| April 2012 through June 30, 2013 | Regions voluntarily forming and meeting statutory criteria will be eligible for TA from DHS. | |
| April 1, 2013 | If regions have not formed, or if there are "orphan" counties, DHS may step in to negotiate and/or assign membership. | |

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|---|---|---|
| | region. | |
| July 1, 2013 | All regions meet the "formation" criteria listed above. | Between 7/1/13 and 6/30/13 the regions could potentially be operating under "one plan" and a unified financial management system, but they could also be operating as "virtual regions as they work to meet the "implementation" criteria by 7/1/14. |
| July 1, 2014 | All regions meet the "implementation" criteria listed above. | |

### *E. Discussion of the roles of regions in the management of Medicaid Home and Community Based Services*

One issue for the roles and functions of regions is participation in the interface with Medicaid programs. Many individuals served under the regions and their designated TCM providers will be on Medicaid, and some people on Medicaid will also be receiving non-Medicaid services under the auspices of the regions.

A discussion of this interface can be informed by consideration of the current HCBS program. Currently there is a statewide set of HCBS slots (not allocated to regions or counties) and there is a statewide waiting list for HCBS services. Under the provisions of SF 525, in the future Counties (and therefore regions) will no longer be paying match for HCBS services. Finally, the federal CMS has become very clear with states that their HCBS programs must be state managed, RLS consistent and equitable statewide.

Thus, it will be beneficial for the regionalization Workgroup to discuss and consider recommendations related to how regions can effectively participate in and add value to the citizens, providers and state agencies (DHS/IME) participating in the HCBS program.

The following are some elements to be considered:

- Consistency of TCM/supports coordination.
- Regional role in the use/oversight of SIS assessment and resource allotment process.
- Potential role of regions in facilitating consumer self-direction under this or future waivers.

- Potential regional role in reviewing and approving individual participant person centered plans.
- Potential regional quality assurance/quality management activities and initiatives in compliance with CMS quality standards and process.
- Potential interaction with DHS/IME related to HCBS waiver accountability and performance.

To the extent there is consensus about approaches to coordination with Medicaid, TAC will amend the draft interim report to reflect the new recommendations.